IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

DEBRA RANSOM, R.N.,R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0036
PHONE 208-334-6626
FAX 208-364-1888

August 31, 2007

Ken Harman
IHC Home Care of CRMC
1501 Hiland Avenue
Burley, Idaho 83318

Dear Mr. Harman:

This is to advise you of the findings of the Recertification survey at IHC Home Care which was concluded on August 9, 2007.

Enclosed is a Statement of Deficiencies/Plan of Correction, Form CMS-2567, listing Medicare deficiencies and a similar form listing State licensure deficiencies. In the spaces provided on the right side of each sheet, please provide a Plan of Correction. It is important that your Plan of Correction address each deficiency in the following manner:

1. Answer the deficiency statement, specifically indicating how the problem will be, or has been, corrected. Do not address the specific examples. Your plan must describe how you will ensure correction for all individuals potentially impacted by the deficient practice.

2. Identify the person or discipline responsible for monitoring the changes in the system to ensure compliance is achieved and maintained. This is to include how the monitoring will be done and at what frequency the person or discipline will do the monitoring.

3. Identify the date each deficiency has been, or will be, corrected.

4. Sign and date the form(s) in the space provided at the bottom of the first page.

After you have completed your Plan of Correction, return the original to this office by **September 13, 2007**, and keep a copy for your records.

Thank you for the courtesies extended to us during our visit. If you have any questions, please call or write this office at (208)334-6626.

Sincerely,

RAE JEAN MCPHILLIPS
Health Facility Surveyor
Non-Long Term Care

SYLVIA CRESWELL
Supervisor
Non-Long Term Care

RM/mlw

Enclosures

Intermountain
Homecare

1501 Hiland Ave.
Burley, Idaho 83318
208.678.8844

September 13, 2007

Patrick Hendrickson R.N., H.F.S.
Rae Jean McPhillips, R.N., H.F.S.
Bureau of Facility Standards
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0036

RE: IHC Home Health of Cassia RMC, provider #137016

Dear Patrick and Rae Jean:

Please find enclosed the Plan of Correction addressing the deficiency from the Medicare survey concluded at our facility on August 9, 2007.
Thank you for professional services.

Leslie Klett

Leslie Klett R.N.
Nurse Manager

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	137016	A. BUILDING _____ B. WING _____	08/09/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IHC HOME CARE	1501 HILAND AVE BURLEY, ID 83318

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 000	INITIAL COMMENTS The following deficiencies were cited during the recertification survey for your home health agency. The surveyors conducting the survey were: Rae Jean McPhillips, RN, HFS Team Coordinator Patrick Hendrickson, RN, HFS Abbreviations for this report include: DVT = Deep Vein Thrombosis PICC = Peripherally Inserted Central Catheter POC = Plan of Care PRN = As Needed PT = Physical Therapist RN = Registered Nurse SN = Skilled Nursing	G 000		
G 159	484.18(a) PLAN OF CARE The plan of care developed in consultation with the agency staff covers all pertinent diagnoses, including mental status, types of services and equipment required, frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, any safety measures to protect against injury, instructions for timely discharge or referral, and any other appropriate items. This STANDARD is not met as evidenced by: Based on review of clinical records and agency policies, observation, and staff interview, it was determined the agency failed to ensure the POCs	G 159	**G 159 PLAN OF CARE** **N 155 PLAN OF CARE** All ordered disciplines will collaborate with the admitting clinician to coordinate care. The admitting clinician will make timely contact with the referring physician to report assessment findings and to develop the visit schedules and plan of care. This will be summarized into an order and sent for physician signature. The plan of care will be ready for dispatch to physician within 5 working days after the admission visit. Procedure orders will be detailed to include: who performs procedure, what supplies are used, frequency, and when it needs to be done. Patient needs will be assessed regularly and timely by following visit schedule and performing prn and or additional visit when there is a change in the patient's condition. The plan of care will be updated to reflect any significant change in care. A group chart audit and discussion will be completed by manager or designee monthly to assure that documentation reflects: 1. orders for each new intervention including admit 2. each clinician's (including aide) visit note documents the ordered interventions 3. POC reasonable, appropriate and consistent based on assessment (review assessment visit)	093007

RECEIVED
SEP 14 2007
FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Lesne Kall RN	nurse manager	09132007

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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G 159	Continued From page 1 for 3 of 15 patients, whose plans of care were reviewed (#s 1, 4 and 5), were developed in consultation with agency staff, covered all pertinent diagnoses, included types of services required, frequency of visits, and other appropriate items. The findings include: * Patient #1 was a 56 year old female with a history of polio. She was admitted to home health services on 7/17/07 for wound care of multiple pressure ulcers. She was discharged from services on 8/7/07. The patient's POC was dated 7/17/07. It called for nursing visits 2 to 3 times a week for coccyx wound care. The plan did not specify what type of dressing the nurse was to use. During a home visit with the nurse on 8/7/07 an adhesive foam dressing was removed from the wound. Observation of the wound by the surveyor revealed the wound was well healed. The nurse stated that she had been treating the ulcers with normal saline for cleansing and using an adhesive foam dressing. She confirmed there was no specific order on how to treat the pressure ulcers. * Patient #4 was a 56 year old female admitted to home health services on 6/21/07 for wound assessment and pain management following surgery for spinal stenosis. The patient's record contained a referral form, dated 6/20/07, ordering SN for wound assessment and pain management. Additionally, the referral contained orders for the PT to evaluated and treat. The POC, dated 6/21/07, documented that SN was to visit 1-2 times a week for 3 weeks. The POC did not document orders for PT services beyond the referral to evaluate. On 7/2/07 the RN documented that the patient's wound had opened and now needed daily monitoring and dressing	G 159		

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G 159	Continued From page 2 changes. RN notes, dated 7/3/07 through 7/19/07, documented the patient's incision was not healing. On 7/20/07 the physician ordered a wound VAC (vacuum assisted closure) to assist in wound healing. The POC did not reflect the patient's need for increased services or specifics on wound dressings for the opened wound. On 8/7/07 at 3:30 PM, the Home Health Director confirmed the POC was not updated when the patient had a significant change in condition and did not include the PT services that were being provided. * Patient #5 was a 82 year old female with a history of diabetes, peripheral vascular disease and a below the knee amputation of the left leg. She was admitted to home health services on 7/27/07 following a femoral-popliteal bypass of the right leg that also included amputation of her right toes. The patient had also developed a DVT in the right lower limb. The patient's POC was dated 7/27/07. It called for nursing visits 1 time per week for 1 week then 2 times a week for 2 weeks. The plan did not direct nursing to assess the patient's surgical incisions, change dressings or assess vascular flow in the right lower extremity. During a home visit with the nurse on 8/7/07 the nurse confirmed there was no specific plan to assess the patient's surgical incisions, change dressings or assess vascular flow in the right lower extremity.	G 159		
G 166	484.18(c) CONFORMANCE WITH PHYSICIAN ORDERS Verbal orders are put in writing and signed and dated with the date of receipt by the registered nurse or qualified therapist (as defined in section 484.4 of this chapter) responsible for furnishing or supervising the ordered services.	G 166		

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G 166	Continued From page 3	G 166		

This STANDARD is not met as evidenced by:
Based on record review and staff interview, it was determined the agency failed to ensure that 3 of 15 records reviewed (#s 4, 7 and 9) contained verbal orders that were countersigned by the physician in a timely manner. Further, the agency failed to adhere to their policy that verbal orders were taken by staff that had authority to receive telephone orders for 3 of 15 records reviewed (#s 7, 9 and 12). Thirdly, the agency failed to ensure that patients' POCs were reviewed and signed in a timely manor for 5 of 15 records reviewed (#s 1, 4, 7, 9 and 15). Lastly, the agency failed to obtain orders for PT and SN services for 1 of 15 patients whose records were reviewed (#4). The finding include:

A. Verbal Orders:

* Patient #4 was a 56 year old female admitted to home health services on 6/21/07 for surgical wound assessment and pain management. The record contained verbal physician's orders received on 7/2, 7/3, 7/5, 7/6, 7/10, 7/11, 7/20, 7/22 and 7/23/07. None of the orders contained in the patient's record were signed by the physician at the time of the survey.

* Patient #7 was a 90 year old female with a history of dementia. She was admitted to home health services on 12/20/06 for urinary catheter care. Review of the patient's physician orders documented a telephone order was received on 3/21/07 for "Aide Per Doctor: 2 times per week for 10 weeks." The physician's verbal orders were not signed until 6/7/07.

G166 CONFORMANCE WITH PHYSICIAN ORDERS

A. Verbal Orders

The intake nurse will track new admissions and 100% of the new charts for timely admission orders and timely completion of the plan of care. Clerical will track orders and POC's daily by using a tickler file. The process is:

1. Fax Plans of Care (POC), recertifications (recert) and orders to out of town physician.
2. Mail POC's, recertifications and orders to local physicians.
3. Make telephone requests after one week for any unsigned POC, recert or order.
4. Fax unsigned POC, recert or order after two weeks
5. Manager will make face to face contact after 3 weeks to request physician signature for unsigned POC, recert and/or orders.

B. Authority to receive orders

The Home Care physical therapist will only receive orders that are "discipline specific" per agency's policy. All other orders will be routed to the intake nurse or staff nurse. Leslie Klett has educated the physical therapist and she has verbalized understanding of the policy and the process.

091207

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G 166	Continued From page 4 * Patient #9 was a 76 year old male with a history of congestive heart failure. He was admitted to home health services on 1/24/07 for nursing care of a PICC line and physical therapy. He was discharged from services on 2/28/07. Review of the patient's medical orders documented the following telephone orders were received and had a significant delay in the authentication of the orders by the physician. Orders received by telephone on 1/24/07, 1/25/07, 1/30/07, 1/31/07, 2/14/07 and 2/19/07 were not authenticated until 3/9/07. On 8/7/07 at 10:30 AM, the facility's administrator confirmed that verbal orders were not being signed by physicians in a timely manner. She further stated, she would like to see orders authenticated by physicians within two weeks of the telephone orders. B. Authority to Receive Telephone Orders: The agency's policy on "Verbal and Telephone Orders", approved on January 2006, documented "Licensed Physical Therapists" were authorized to receive "discipline specific" telephone orders according to "their scope of practice." * Patient #7 was a 90 year old female with a history of dementia. She was admitted for home health services on 12/20/06 for urinary catheter care. Review of the patient's medication orders documented the following telephone orders where taken by the agency's PT: 1/30/07 un-timed, Cipro 250 mg twice a day "purpose: UTI". 2/20/07 un-timed, aspirin 81 mg daily	G 166		

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G 166	Continued From page 5 "purpose: heart". * Patient #9 was a 76 year old male with a history of congestive heart failure. He was admitted for home health services on 1/24/07 for the care of a PICC line and physical therapy. He was discharged from services on 2/28/07. Review or the patient's medication orders documented the following telephone orders where taken by the agency's PT: 1/31/07 un-timed, Lanoxin 0.125 mg 1/2 tablet daily "purpose: heart". 2/20/07 un-timed, aspirin 81 mg daily "purpose: heart". * Patient #12 was a 80 year old female with a history of left sided neck, back and shoulder pain. She was admitted for home health services on 3/21/07 for physical therapy. She was discharged from services on 5/4/07. Review or the patient's medication orders documented the following telephone orders where taken by the agency's PT: 4/23/07 un-timed, Guaifenesin 2 tsp liquid every 4 hours as needed "Purpose: cough congestion". C. Unsigned or Delayed POCs: * Patient #1 was a 56 year old female with a history of polio. She was admitted to home health services on 7/17/07 for wound care of multiple pressure ulcers. She was discharged from services on 8/7/07. Review of the patient's medical record documented that the patient's POC for certification period from 7/17/07 to 9/14/07 was not signed by the attending physician	G 166		

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G 166	Continued From page 6 at the time of the survey. * Patient #4 was a 56 year old female admitted to home health services on 6/21/07 for surgical wound assessment and pain management. The record contained a POC for a certification period of 6/21/07 to 8/19/07. The POC was not signed by the physician at the time of the survey. * Patient #7 was a 90 year old female with a history of dementia. She was admitted to home health services on 12/20/06 for urinary catheter care. Review of the patient's medical record documented that the patient's POC for certification period from 12/22/07 to 3/22/07 was not signed by the attending physician until 2/21/07. Further, the patient's POC for certification period from 5/22/07 to 7/20/07 and for certification period from 7/19/07 to 9/16/07 was not signed by the attending physician at the time of the survey. * Patient #9 was a 76 year old male with a history of congestive heart failure. He was admitted to home health services on 1/24/07 for nursing care of a PICC line and physical therapy. He was discharged from services on 2/28/07. The patient's medical record documented that the patient's POC for certification period from 1/24/07 to 3/24/07 was not signed by the attending physician until 3/9/07 and was not received by the agency until 3/20/07. * Patient #15 was a 96 year old female with a history of falls. She was admitted to home health services on 5/17/07 for physical therapy. She was discharged from services on 7/26/07. Review of the patient's medical record documented that the patient's POC for	G 166		

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G 166	Continued From page 7 certification period from 5/17/07 to 7/15/07 was not received at the agency until 8/9/07. On 8/7/07 at 10:30 AM, the facility's administrator confirmed that patients' POCs were not being signed by physicians in a timely manner. D. Not Obtaining Physician's Orders * Patient #4 was a 56 year old female admitted to home health services on 6/21/07 for wound assessment and pain management following surgery for spinal stenosis. The patient's record contained a referral form, dated 6/20/07, ordering SN for wound assessment and pain management and PT to evaluate and treat. The POC, dated 6/21/07, documented that SN was to visit 1-2 times a week for 3 weeks. The POC did not document orders for PT services beyond the referral to evaluate. The patient's record contained PT notes that documented PT visits on the following dates: 7/6, 7/9, 7/12, 7/16, and 7/19/07 without physician's orders. Additionally, the record contained a physician's order, dated 7/20/07, for SN visits 1 times a day for 4 days, then 2-3 times a week for 4 weeks, with 1 PRN visit. The order authorized the visitation schedule to start on 7/21/07. RN visit notes documented the RN provided services to the patient for 6 days beyond the physician's orders. On 8/7/07 at 3:30 PM, the Home Health Director confirmed there were no physician's orders in place for PT services from 7/6/07 to 7/19/07. Additionally, she confirmed the RN provided services on 6 occasions without a physician's order.	G 166		

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N 155	03.07030. PLAN OF CARE N155 01. Written Plan of Care. A written plan of care shall be developed and implemented for each patient by all disciplines providing services for that patient. Care follows the written plan of care and includes: c. Types of services and equipment required; This Rule is not met as evidenced by: Refer to Federal deficiency G 159, as it relates to the failure of the agency to ensure the plan of cares were developed in consultation with agency staff, covered all pertinent diagnoses, included types of services required, frequency of visits, and other appropriate items.	N 155	**G 159 PLAN OF CARE** **N 155 PLAN OF CARE** All ordered disciplines will collaborate with the admitting clinician to coordinate care. The admitting clinician will make timely contact with the referring physician to report assessment findings and to develop the visit schedules and plan of care. This will be summarized into an order and sent for physician signature. The plan of care will be ready for dispatch to physician within 5 working days after the admission visit. Procedure orders will be detailed to include: who performs procedure, what supplies are used, frequency, and when it needs to be done. Patient needs will be assessed regularly and timely by following visit schedule and performing prn and or additional visit when there is a change in the patient's condition. The plan of care will be updated to reflect any significant change in care. A group chart audit and discussion will be completed by manager or designee monthly to assure that documentation reflects: 1. orders for each new intervention including admit 2. each clinician's (including aide) visit note documents the ordered interventions 3. POC reasonable, appropriate and consistent based on assessment (review assessment visit)	093007

Bureau of Facility Standards

Legin Rhett Nurse Manager 09/13/2007 TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE